AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	A. BUILDING 00 COMPI		(X3) DATE SURVEY COMPLETED 03/25/2011
	PROVIDER OR SUPPLIEI F HUNTINGBURG		510 WE	EST MEDCALF IN47523	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0000	Licensure surve	ar a Recertification and y. arch 21, 22, 23, 24, 25,	F0000		
	Facility number: Provider number Aim number: 10	r: 155270			
	Survey team: Carole McDaniel RN TC Martha Saull RN Liz Harper RN				
	Census bed type SNF/NF: 45 Total: 45	:			
	Census payor ty Medicare: 1 Medicaid: 40 Other: 4 Total: 45	pe:			
	Sample: 12				
		es also reflect State a accordance with 410			
	Quality review of Cathy Emswiller	completed 3-29-11 r RN			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID:

000170

TITLE

If continuation sheet

(X6) DATE

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COMPI 03/25/2	LETED	
	PROVIDER OR SUPPLIER F HUNTINGBURG			510 WE	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID: 000170

If continuation sheet

Page 2 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155270	B. WIN			03/25/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				EST MEDCALF	
CORE O	F HUNTINGBURG I	INC			IN47523	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0225	Based on record review and interview,		F022	25	It is the policy of this facility thoroughly investigate past work	
SS=E		to thoroughly investigate			histories of applicants by	^N
	past work histori	es of applicants by			reference checks prior to hire.2	
	reference checks	prior to hire for 4 of 4			All other employee files will be	
	employee files re	eviewed. RN #2, CNA #1,			reviewed to ensure they have t	he
	CNA #2 and Coo	ok #1			appropriate references. The	
	CNA #2 and Cook #1 Findings include:				affected staff members Reference Checks have been completed to ensure compliant and they include RN #1, CNA #	
	Om 2/22/11 at 10	:00 A.M., the staff			and #2, and Cook #1.3. A new	
		*			Employee Reference Form has	l l
		e reviewed for reference			been developed to include both	
		plications indicated 3			personal and professional chec	
		nt contacts and 3 personal			and is being used prior to offeri employment. The Administrato	
		ces for RN #2, CNA #1,			is checking the reference form	"
	CNA #2 and Coo	ok #1.			prior to approving any new hire A new policy has been written	
	Documentation v	was lacking to indicate			regarding Refence Checks price	r
		ade to check references			to employment.4. The	
		es for RN #2, CNA #1,			Administrator or Designee is	
	CNA #2 and Coo				checking all new employee files to ensure reference checks are	
	C1 17 1 11 2 and C00	/K // 1 ,			complete. All other files will be	l l
	On 3/24/11 at 9:0	00 A M the			audited and updated with curre	l l
					reference forms if not complete	
	*	orm indicated to "-check			already. The Administrator will	
	` *	oyment history and			audit employee files weekly for	
	personal reference	ces)."			six weeks and monthly thereaft to ensure compliance.	er
	On 3/24/11 at 10	:00 A.M. the				
	Administrator wa	as interviewed. She				
		ieved prior employers of				
		employees would provide				
		yed but documentation				
	-	rith the employers was				
		in the employers was				
	lacking.					

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CO	INSTRUCTION 00	(X3) DATE COMPI	
ANDIEAN	or correction	155270	A. BUIL B. WING			03/25/2	
NAME OF F	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF				
CORE OF HUNTINGBURG INC				DALE, I	N47523		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	Ι .	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DEFICIENCY)	
<u>'</u>	3.1-14(t)		Ì				
	3.1-14(t)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID: 000170

If continuation sheet

Page 4 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155270 03/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 510 WEST MEDCALF CORE OF HUNTINGBURG INC DALE, IN47523 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE It is the policy of this facility to F0250 Based on observation, interview and F0250 04/24/2011 provide medically related social record review, the facility failed to ensure SS=E services to attain or maintain the the resident's behaviors and/or hightest practicable physical, psychosocial needs were monitored and/or mental and psychosocial well-being of each resident.1] A assessed and/or evaluated for new digital camera system was effectiveness of interventions, if and when purchased to provide Elopement attempted to, modify the behaviors for 4 Book pictures in a timely of 4 residents reviewed with a history of manner.2] Elopement Book elopement attempts and/or 1 of 1 resident pictures and Elopement Assessment, Prevention and (Resident #35) with an observed Management Care Plan will be elopement attempt in a sample of 12. initiated within 24 hours of Resident #35, Resident #42, Resident #15, Wanderquard order from Resident #5 Physician.3] Elopement Policy will be re-inserviced to all employees by April 24, 2011.4] Findings include: The Director of Nursing will conduct daily audits of the Elopement Book/Careplan x 2 The clinical record of Resident #35 was weeks, weekly audit x 2 weeks, reviewed on 3 /21/11 at 12:50 P.M. bi-weekly audits x 4 weeks, then Diagnoses included, but were not limited monthly there after.1) Social to the following: Dementia, Depression, Services will implement a new Chronic Obstructive Pulmonary Disease, policy and procedure for 1:1 supervision of residents and Anemia, Seizure Disorder, Diabetic Type tracking form to be used. Staff to II, Aphasia and history of stroke. The be inserviced on the new policy.2) most recent MDS (minimum data set Nurses on duty will initiate the 1:1 assessment) dated 2/27/11 indicated the supervision and complete the 1:1 form and assign a staff member following for the resident: short to do the 1:1 and track the mood tempered/easily annoyed several days; and activity of the resident.3) verbal behavioral symptoms exhibited Social Services will review and toward others occurred 1 to 3 days; monitor the occurences of the 1:1 supervision daily during clinical wandered daily; locomotion on and off review. unit required supervision - oversight, encouragement or cueing; height 64 inches (5 feet, 4 inches) weight 196 pounds.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID:

000170 If continuation sheet

Page 5 of 54

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MULTIPLE CC A. BUILDING B. WING	00	i i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIEF		510 WE	ADDRESS, CITY, STATE, ZIP EST MEDCALF IN47523	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	on 2/18/11. An awas dated 2/18/1 included, but wa following: resid mobile, cognitive seeking. An assessment of 2/22/11 included the following: "memory impaired moderately impaired moderately impaired moderately impaired was noted in the following: "memory impaired moderately impaired moderately impaired was noted in the following: "memory impaired moderately impaired was noted in the following: "memory impaired moderately impaired was noted in the following: "memory	icated the following: 30 (1:30 P.M.): d to facility veral attempts to leave ard on. Has been getting when redirected from e unit" ecoming increased gression toward active, wandering into ag at locked doors - ion with agitation when redirect" ndicated the resident was ecks starting at 2:30 P.M.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 7/2011	
	PROVIDER OR SUPPLIEF		510 WE	ADDRESS, CITY, STATE, ZIF EST MEDCALF N47523	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	attempting to exi	es (resident) continuously it bldg (building). ns/symptoms) physical				
	At 5:30 P.M. "Attempted to go out exit door by DR (dining room) few times. Unable to redirect" At 10:00 P.M.: "cont (continue) to attempt to open exit doors"					
	redirect. Trying to exit door et (a	:10 A.M.: "Very hard to to elope from unit. Goes nd) pulls on ittried to I tries to elope from both				
	At 1 P.M.: "Try: redirects poorly	ing to exit unit againbut from exit."				
	placed in w/c (w	Packed clothing et (and) heelchair). Attempting to lery resistive et becoming				
	agitated, slappinget out of locked pull doors and se Redirect not effe away.""	Resident severely g at nurse as she tries to unit. Cont (continue) to et off door alarm. ctive, yelling to "get ated 2/21/11, indicated				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155270	A. BUI		00	03/25/20	
		100270	B. WIN		DDDEGG CITY GTATE ZID CODE	00/20/20	711
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG I	INC		1	N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		-	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
I	the following: "	Wandering, potential for	İ			İ	
	elopement or safe	ety risk related to: Lost,					
	restless, environmental stimuli" On 2/22/11 at 10:00 A.M.: "disoriented						
	_	Wandering more today et					
		redirectrequires 1:1					
	attention"						
	On 2/24/11 at & I	DM· " Is constantly					
	On 2/24/11 at 8 P.M.: "Is constantly trying to open unit door"						
	l dying to open un	iit d 001					
	On 2/26/11 at 00.	20 (12:20 A.M.):					
		ie) to exit seek setting					
	· ·	s inappropriate comments					
	to other residents	s and staff. Redirection is					
	not effectiveWa	anderguard on left					
	ankle"						
		:00 A.M.: "Has been					
		pting to seek exit from					
		accessful et resident on					
		h redirection. Very					
	1 *	npting these behaviors et					
		t." This entry was					
	documented by F	Μ 1.					
	On 3/23/11 at 9 A	A.M. RN #1 was					
		e indicated the resident					
		the unit but when she					
	stated "successfu						
	resident's 1:1 was						
	On 2/27/11 at 12	P.M.: "Resident					

000170

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155270	A. BUI		00	03/25/2011
		100270	B. WIN		ADDRESS CITY STATE TINCODE	00/20/2011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CORE O	F HUNTINGBURG I			1	N47523	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAG		rs with time after time		TAG	DLI ICILICI I	DATE
	exit seeking 1:1 with nursing staff who is standing between her and doors to prevent					
	_	has wanderguard but has				
	_	em will release after				
		re. Very agitated et				
	_	cal aggression with				
		nursing assistant) and				
	nurses"					
	2242 50000					
	At 5:45 P.M.: "V	Was able to pull on unit				
		get them open. Staff was				
		hallway, but resident				
	exited before the	y could reach her.				
	Resident was cor	nbative with staff and				
	was cursing. Sta	ff has been redirecting				
	this resident all s	hift away from doors and				
	out of resident ro	oms and away from				
	nurses area"					
		Is constantly attempting				
		an be redirected at times				
	but has been mos	stly uncooperative"				
	On 2/1/11 -4 O A	M. IITmin a const				
		.M.: "Trying several				
		. Stays at exit door et				
	difficult to redire	Cl				
	 Δ+ 10·30 A M· '	"Resident at exit door.				
	Has a bag of clot					
	_	ve unit several times.				
	Very difficult to i					
	. or y difficult to i					
						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	COM	e survey IPLETED 5/2011	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP C ST MEDCALF N47523	CODE	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION
TAG	On 3/3/11 at 12:4 attempts to eloped door to back door staff; yelling low attempting to redunredirectable [sexits" On 3/4/11 at 1 P. elope between by Went to both exicelope" At 9:30 P.M.: "Verticology (rooms) exit seed become phy (phy (aggressive)" On 3/11/11 at 8 I most of evening redirect at x's (time On 3/15/11 at 7:3 elopement behave On 3/16/11 at 2:3 exhibiting eloper On 3/17/11 at 9:3 aggression since doors, attempting On 3/19/11 at 9:4	ic] - guarding the M.: "Intensely trying to reakfast and 10:30 A.M. t doors et tried to Wandering into rms raing attempting to residually) agg P.M.: "Resident has tried to elope - difficult to mes)" 30 P.M.: "Res exhibiting riors." 15 P.M. and 4 P.M., "Res. ment behaviors." 30 A.M., "Increased morning. Pulling on unit		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MULTIPLE CC A. BUILDING B. WING	00	i i	e survey pleted /2011	
	PROVIDER OR SUPPLIER F HUNTINGBURG		510 WE	ADDRESS, CITY, STATE, ZIP EST MEDCALF IN47523	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	with staffvery direction. Has b wait till alarm so out" Nurses notes dat indicated the follunit. More difficulated the follunit slightly with cur with staff outside outdoors. Resist documented by I on 3/23/11 at 11 interviewed regas She indicated the get off the unit." only one on the wait heard the alarm get to the resident the indicated the resident the indicated she sur other unit and staff outside. LPN #1	has been combative reluctant to change een exit seeking and will bunds solid and then walk ed 3/20/11 at 12:30 P.M. lowing: "Tried to leave cult to redirect." ed 3/20/11 at 1:45 P.M. lowing: "Got out of unit, rsing. Went on a walk e of unit. Tried to go iive." This entry was				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLET	ΓED
		155270	B. WIN			03/25/20	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIER				EST MEDCALF		
CORE O	F HUNTINGBURG	NC		1	IN47523		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		P.M., the Elopement					
	Book on the secure unit was observed.						
	This book had a total of 15 resident						
	descriptions in it	Current photographs					
	were lacking for	4 residents, of which					
	included residen	ts #35, #42, #15 and #5.					
	At 12:45 P.M., th	ne DON was interviewed.					
	She indicated the	facility camera broke					
		left on vacation (on					
		aff member was going to					
		camera to use. She					
		nts #5 and #15 refused to					
		taken. Resident #42 had					
		the unit on $3/2/11$ and					
		been admitted to the					
		The DON indicated there					
		ent book in the facility					
	which was house	d on the east unit.					
	On 3/22/11 at 1:3	30 P.M., a current,					
	undated, copy of	the policy and procedure					
	for "Elopement I	Policy and Procedure"					
	1 *	the SSD (social service					
	1 1	olicy included, but was					
		e following: "maintain a					
	1	list of names and					
		esidents identified to be					
	at risk for elopen						
	at risk for clopen						
	On 3/22/11 at 1:5	50 P.M., Resident #35					
		oroaching the interior,					
		The doors had not been					
		light was able to be					
	1 tarry crosed and	115111 1140 4010 10 00					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	03/25/20	
		155270	B. WIN			03/23/20	711
NAME OF	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG	INC		1	N47523		
			-	<u>.</u>			(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	observed betwee	n the doors (of which one					
		e alarm sounded as					
	Resident #35 was walking towards the						
		door had a window					
	1 *	pper portion. Resident					
	1	loor and stood in the					
	_	tor in the hall from					
	1 -	blocked the resident from					
	1	ged the resident in					
		ne resident was standing					
		unattended. No staff					
	were observed in the interior unit or						
		way. At 1:57 P.M., CNA					
		ne resident from inside					
		time, the PT (Physical					
		or approached the unit					
	1 ***	door. He indicated the					
		was not closed/latched					
	1	ind outside and the air					
	flow/pressure in						
	_	le lot of air flooding					
		en the doors are open on					
	1	residents to go outside for					
		He indicated the wind					
		and the door doesn't					
	close all the way						
	On 3/22/11 at 2:4	45 P.M., the DON was					
	interviewed. She						
	documentation w	as lacking of an					
		ment assessment of this					
	1	inical record. She					
		ident had a wanderguard					
		idmission due to her					

000170

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/25/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF DALE, IN47523				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	this time, the DO "Elopement plan prevention and m 3/22/11. This for limited to the fol elopement histor leave, impaired of mobileanxious, restless, irritable, behavior." On 3/23/11 at 9 A 3/22/11 were rev but were not limi (The first entry a P.M.: "continue at 8 P.M.: "incre (multiple) attempt Aggressive with attempted" Do of the above circ with the unit doo P.M. On 3/23//11 at 11 Service Director) Nursing) were in indicated the abo indicate the resid They indicated th resident having g time. They indicated	of care: Assessment, nanagement" dated rm included but was not lowing: "Risk factors: y, expresses desire to cognitionindependently psychiatric history,history of exit seeking A.M., nurses notes for iewed. They included ted to the following: fter a 1 P.M. note): At 6 to monitor for changes"; cased behaviors, mult obts at elopement. staff, when redirection cumentation was lacking umstances of the resident r open on 3/22/11 at 1:50 A.M., the SSD (Social and DON (Director of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155270	A. BUILI B. WING			03/25/2	
NAME OF I	DROWNER OR CURRY IER		p. whve		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER				ST MEDCALF		
CORE O	F HUNTINGBURG I	INC		DALE, II	N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAO	 	ras at prior to this		IAU			DATE
	1	loped from the building.					
	damission, she el	toped from the building.					
	On 3/24/11 at 1:3	30 P.M., the SSD was					
		e indicated the facility					
	"really doesn't ha	eve a policy and					
	1 -	monitoring" and					
	indicated they us	e the care plan "Behavior					
	Management Car	replan." She indicated a					
	resident is placed	l on 15 minutes checks if					
	they have a phys	ical or verbal behavior					
		is kept on 15 minute					
		urs. She indicated the					
		1:1 monitoring if the					
		le to be redirected or acts					
		lse. She indicated this					
		n on 1:1s a lot." She					
		ility didn't really have a					
	_	they just document in					
		nd continue this until the					
		She indicated if the					
		lmed down in 2 hours,					
		called. Interventions on					
		nagement Care plan,					
	1	ded by the SSD on P.M., included but were					
		following: "Allow					
		ss feelings: Allow					
	1 ^	lly guide you through the					
		of daily living) process;					
		ving inappropriate					
		ow quiet time; provide					
		and allow quiet time;					
		g coping strategies;					
		<u> </u>					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155270	B. WIN			03/25/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ST MEDCALF		
CORE O	F HUNTINGBURG	INC		1	N47523		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
		nificant) behavior					
	occurs:ensure	safety of residentcontact					
	SSD or DONlo	og behavior on 72 hour					
	acute charting ar	nd nurses notes,use one					
	of the following	until beh (behavior)					
	resolved: 1:1, 1:	5 min checks, med change					
	per MD (medica						
		,					
	On 3/25/11 at 11	:20 A.M., the DON					
	(Director of Nur	sing) was interviewed.					
	She indicated aft	ter reviewing the resident					
		2/22/11 at 10 A.M. and					
		M., she was unable to					
		g the resident was on					
	<u> </u>	to track or trend the					
	circumstances ar						
		resolution of the behavior					
		nt. The DON indicated a					
		upervision was more					
		ng than a resident on 15					
		nd the facility did not					
		and procedure for 1:1					
	1	sidents and or no form to					
	document and/or						
	1 *	e DON indicated the SSD					
		esident is to be on 1:1					
	_	e indicated she and the					
		documented 15 minute					
		y for tracking and					
	trending.						
	A 11 - £ 41 1	udle essist esseit es estes					
		nt's social service notes					
		or the entries of February					
	2011. Entries w	ere documented for					

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270 NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC		LDING STREET A 510 WE	DNSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523	(X3) DATE COMPI 03/25/2	LETED	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		and 2/28/11. was lacking of the been on 1:1 supervision.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

000170

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155270		A. BUILDING 00 CC			(X3) DATE : COMPL 03/25/2	ETED	
	PROVIDER OR SUPPLIER F HUNTINGBURG I			STREET A	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523		
(X4) ID PREFIX TAG F0272 SS=D	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 60272 Based on observation, interview and	F02	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEPICIENCY) It is the policy of this facility to conduct initially and periodically comprehensive assessment of each resident's functional capacity.1) Resident #35 was unable to be interviewed for demographic information. Proceeded with the completion the assessment and notified the resident's children for more accurate information. 2) Social Services reviewed current	y a of e	COMPLETION DATE 04/24/2011	
	Findings include The clinical recoreviewed on 3 /2 Diagnoses include to the following: Chronic Obstruct Anemia, Seizure II, Aphasia and homost recent MDS assessment) date following for the tempered/easily averbal behavioratoward others occurate wandered daily; unit required supencouragement of inches (5 feet, 4 pounds. The resident was	rd of Resident #35 was 1/11 at 12:50 P.M. led but were not limited Dementia, Depression, tive Pulmonary Disease, Disorder, Diabetic Type listory of stroke. The 6 (minimum data set d 2/27/11 indicated the			comprehensive assessment armade revisions to include all the documentation required by the RAI specified by the state.3) All other resident charts to be audited for completion of the assessment and reviewed. 4) Social Service Comprehensive assessment is to be completed admission and reviewed quarterly.	e I	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	Ì	LDING	NSTRUCTION 00	COM	TE SURVEY IPLETED 5/2011
	PROVIDER OR SUPPLIER		р. үүлү	STREET A	DDRESS, CITY, STATE, ZIP C ST MEDCALF N47523	CODE	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION
	was dated 2/18/1 included, but was following: reside mobile, cognitive seeking. An assessment of 2/22/11 included the following: "seeking memory impaired moderately impaired moderately impaired moderately impaired moderately impaired and a little agitated was a little agitated was attempts to leave the At 2:30 P.M. "Be anxious with agg staffconstantly rooms and pulling frequent redirect staff attempts to a Documentation in second moderate or staff attempts to a pocumentation in the second moderate of the second moderat	1. The assessment is not limited to, the ent is independently ely impaired and is exit of cognitive status, dated in the property of the ent is independently ely impaired and is exit of cognitive status, dated in the ent is independently ely impaired and is exit of cognitive status, dated in the ent is independently ely impaired and is exit of cognitive status, dated in the ent is independently ely impaired and long term in district daily decisions it in the entire elicities of the		PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	
	At 3:30 P.M. "Reattempting to exi	es (resident) continuously					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		A. BUII	LDING	NSTRUCTION 00	CO	MTE SURVEY MPLETED 5/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO ST MEDCALF N47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	aggression" At 5:30 P M "At	tempted to go out exit					
		ng room) few times.					
	At 10:00 P.M.: 'attempt to open 6	"cont (continue) to exit doors"					
	redirect. Trying to exit door et (as	:10 A.M.: "Very hard to to elope from unit. Goes and) pulls on ittried to tries to elope from both					
	At 1 P.M.: "Tryi redirects poorly to	ng to exit unit againbut from exit."					
	placed in w/c (w)	Packed clothing et (and) heelchair). Attempting to ery resistive et becoming					
	get out of locked pull doors and se	g at nurse as she tries to unit. Cont (continue) to					
	the following: "	ated 2/21/11, indicated Wandering, potential for ety risk related to: Lost, mental stimuli"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	COMPL	ETED	
		155270	B. WIN			03/25/2	U11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG I	NC			ST MEDCALF N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to time et place. more difficult to attention" On 2/24/11 at 8 F trying to open un On 2/26/11 at 002 "Cont. (continu alarm off. Makes to other residents						
	constantly attempunit - has been sult:1agitated with	200 A.M.: "Has been bring to seek exit from accessful et resident on the redirection. Very apting these behaviors et t." This entry was 2N #1.					
		e indicated the resident the unit but when she l" she meant the					
	exit seeking 1:1 v	P.M.: "Resident rs with time after time with nursing staff who is her and doors to prevent					

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155270	A. BUII	LDING	00	COMPL: 03/25/20	
		155270	B. WIN			03/23/20	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG I	NC		1	EST MEDCALF N47523		
				<u>.</u>	1147323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
1110		has wanderguard but has	+	1110			DITE
	Ū	em will release after					
		re. Very agitated et					
	_						
		cal aggression with					
	nurses"	nursing assistant) and					
	nurses						
	A + 5 · 45 D M · "V	Voc able to pull an unit					
		Was able to pull on unit					
		get them open. Staff was					
	_	hallway, but resident					
		y could reach her.					
		mbative with staff and					
	_	ff has been redirecting					
		hift away from doors and					
		oms and away from					
	nurses area"						
	A+ 0.20 D M · "	Is constantly attempting					
		an be redirected at times					
		stly uncooperative"					
	out has been mos	sity uncooperative					
	On 3/1/11 at 0 A	.M.: "Trying several					
		. Stays at exit door et					
	difficult to redire	-					
	difficult to redire	Ct					
	 At 10:30 A M · '	"Resident at exit door.					
	Has a bag of clot						
	_	ve unit several times.					
	Very difficult to i						
		ounou					
	On 3/3/11 at 12:4	40 P.M.: "continual					
		from unit - from front					
		r - very aggressive with					
	acci to back doo.	i vory uggressive with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155270			ULTIPLE CO LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED	
		155270	B. WIN				5/2011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CO ST MEDCALF	DDE	
CORE O	F HUNTINGBURG	INC		DALE, I			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION
TAG	staff; yelling loud attempting to red unredirectable - On 3/4/11 at 1 P. elope between by Went to both existed become phy (phy (aggressive)" On 3/11/11 at 8 I most of evening redirect at x's (time on 3/15/11 at 7:2 elopement behave on 3/16/11 at 2:2 exhibiting eloper on 3/17/11 at 9:3 aggression since doors, attempting on 3/19/11 at 9 averbally aggression shift. Redirects parts of the staff of the st	M.: "Intensely trying to reakfast and 10:30 A.M. to doors et tried to Wandering into rms tring attempting to resically) agg P.M.: "Resident has tried to elope - difficult to mes)" 80 P.M.: "Res exhibiting riors." 15 P.M. and 4 P.M., "Res. ment behaviors." 80 A.M., "Increased morning. Pulling on unit gelopement." A.M.: "Resident ve et trying to elope all		TAG		PPROPRIATE	DATE
1		reluctant to change					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		510 WI	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		een exit seeking and will unds solid and then walk			
		ed 3/20/11 at 12:30 P.M. owing: "Tried to leave cult to redirect."			
	indicated the foll slightly with cur with staff outside	ed 3/20/11 at 1:45 P.M. owing: "Got out of unit, sing. Went on a walk of unit. Tried to go ive." This entry was LPN #1.			
	interviewed regations indicated the get off the unit." only one on the unit heard the alarm get to the resident the indicated the resident the indicated the resident the indicated she surrother unit and state outside. LPN #1	eresident "didn't really She indicated "I was the unit at the time" and she go off and when she got e door was opened. She dent got the door opened ant pressure on it. She mmoned help from the aff walked the resident obeing returned inside			
	interviewed. She documentation w				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND FLAN	OF CORRECTION	155270	1	LDING	00	03/25/2	
		100210	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIER				ST MEDCALF		
	F HUNTINGBURG			DALE, I			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	1	inical record. She		IAG			DAIL
		dent had a wanderguard					
		dmission due to her					
	1 ^	nent at prior facility. At					
	this time, the DO						
		of care: Assessment,					
		nanagement" dated					
	1 ^	rm included but was not					
		lowing: "Risk factors:					
		y, expresses desire to					
	_	eognitionindependently					
		, psychiatric history,					
		history of exit seeking					
	behavior."						
	On 3/23/11 at 9 A	A.M., nurses notes for					
	3/22/11 were rev	iewed. They included					
	but were not limi	ited to the following:					
	(The first entry a	fter a 1 P.M. note): At 6					
	P.M.: "continue	to monitor for changes";					
		eased behaviors, mult					
	(multiple) attemp	•					
	""	staff, when redirection					
	1 ^	cumentation was lacking					
		umstances of the resident					
		or open on 3/22/11 at 1:50					
	P.M.						
	0.000000	A 3.6 14 100F (2					
		A.M., the SSD (Social					
	1	and DON (Director of					
	Nursing) were in	-					
		ve 2 P.M. entry did not					
		ent was off of the unit.					
	They indicated the	ney were not aware of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED						
AND PLAN	OF CORRECTION		A.	BUILDING	-	00		03/25/2	
		155270	В.	WING				03/25/2	UII
NAME OF F	PROVIDER OR SUPPLIER	R				RESS, CITY, STAT	ΓE, ZIP CODE		
CORE	F HUNTINGBURG I	INC		DALE		MEDCALF			
					., 11947	J2J			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU					
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	C	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
		gotten off the unit at any			1				
	1	icated the reason the							
	1	nitted here was because at							
		vas at prior to this							
	I -	eloped from the building.							
		ropou nom mo oumumg.							
	On 3/24/11 at 1:3	30 P.M., the SSD was							
		e indicated the facility							
	"really doesn't ha	•							
	1 -	1 monitoring" and							
	^	se the care plan "Behavior							
		replan." She indicated a							
	_	d on 15 minutes checks if							
		sical or verbal behavior							
		is kept on 15 minute							
		ours. She indicated the							
		n 1:1 monitoring if the							
		ole to be redirected or acts							
	out at someone e	else. She indicated this							
	resident has "bee	en on 1:1s a lot." She							
	indicated the faci	cility didn't really have a							
		n they just document in							
	_	nd continue this until the							
	resident is calm.	She indicated if the							
	resident is not ca	almed down in 2 hours,							
	the physician is o	called. On the blank							
	Behavior Manag	gement Careplan, provided							
	_	/24/11 at 1:30 P.M.,							
	interventions inc	cluded but were not							
	limited to the fol	llowing: "Allow resident							
	to express feeling	gs: Allow resident to							
	verbally guide yo	ou through the ADL							
	(activities of dail	ly living) process; redirect							
		ppropriate behavior and							
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	RH6	Y11 Facili	ty ID:	000170	If continuation sl	neet Pa	ge 26 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
AND TEAN	or conduction	155270	A. BUIL			03/25/2	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIER				ST MEDCALF		
	F HUNTINGBURG				N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	\	provide 1:1 conversation		0			BINE
		ime; educate regarding					
	coping strategies						
	1	avior occurs:ensure					
		tcontact SSD or					
	1 -	rior on 72 hour acute					
	_	ses notes,use one of the					
	1	eh (behavior) resolved:					
	_	ks, med change per MD					
	(medical doctor)	"					
	On 3/25/11 at 11	:20 A.M., the DON					
	(Director of Nurs	sing) was interviewed.					
	She indicated aft	er reviewing the resident					
	nurses notes on 2	2/22/11 at 10 A.M. and					
	2/27/11 at 10 A.M	M., she was unable to					
	identify how long	g the resident was on					
	1:1s, and unable	to track or trend the					
	circumstances an	nd/or attempted					
	interventions of i	resolution of the behavior					
	of the 1:1 incides	nt. The DON indicated a					
		upervision was more					
		ng than a resident on 15					
		nd the facility did not					
		and procedure for 1:1					
	1	sidents and or no form to					
	document and/or						
	1 ^	e DON indicated the SSD					
		esident is to be on 1:1					
	1 ^	e indicated she and the					
		documented 15 minute					
		y for tracking and					
	trending.						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE COMP 03/25/2	LETED
	PROVIDER OR SUPPLIED F HUNTINGBURG		•	510 WE	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
	were reviewed 2011. Entries v 2/18/11, 2/22/1 Documentation	ent's social service notes for the entries of February were documented for 1 and 2/28/11. was lacking of the been on 1:1 supervision.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID: 000170

If continuation sheet

Page 28 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155270 03/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 510 WEST MEDCALF CORE OF HUNTINGBURG INC DALE, IN47523 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0282 Based on record review and observation, F0282 It is the policy of this facility to 04/24/2011 provide services or arrange for the facility failed to ensure Certified SS=D services to be provided by Nurse Aides did not perform tasks/duties qualified persons in accordance outside their scope of practice and for with each resident's written plan which they had not been trained for 1 of 4 of care.1] All nursing employees will be inserviced on residents from a sample of 4 observed to proper licensed personnel to do receive care by Certified Nurses Aides. all treatments and dressing (Resident # 12) application/removal by April 24, 2011.21 All employees will be inserviced on proper glove use Findings include: and handwashing techniques by April 24, 2011. 3] On 3/22/11 at 9:15 A.M., during Handwashing/Antimicrobial gel observation for a bathing activity, it was use will be monitored daily x 2 weeks, weekly x 2 weeks, observed that after Resident # 12 was bi-weekly x 4 weeks, monthly x 2 transferred from the wheelchair to a months, then quarterly thereafter. sitting position inside the whirlpool. Nurses aide #3, wearing gloves, removed the residents clothing and removed the dressing from the residents right outer ankle. Nurse Aide # 3 placed her gloves and dressing in the trash and left the room without handwashing. The clinical record of Resident #12 was reviewed on 3/23/11 at 9:30 A.M. Diagnosis' included, but were not limited to, recurrent wound of the lower extremity, hepatitis C, insulin dependent diabetes, and right hemiparesis. A physician's order dated 2/5/11 for treatment to the right outer melleous indicated to cleanse with wound cleanser, cover wound with collagen and bactroban,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID:

000170 If continuation sheet

Page 29 of 54

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMP	LETED
		155270		UILDING		03/25/2	2011
			B. W.		DDDDGG GYBY GDDD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					EST MEDCALF		
CORE O	F HUNTINGBURG	INC		DALE, I	N47523		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
İ	cover with dry d	lressing daily.	ĺ				
	 	2 3					
	The State of Ind	iana Nurse Aide training					
		•					
		ı, Copyright, July, 1998					
	reviewed on 3/2	5/11 at 10:00 A.M., did					
	not include train	ing for removal of					
	dressing(s) as pa	art of the Nurse Aide					
	Scope of Practic						
	Scope of Fractic	ve.					
	2.1.25()						
	3.1-35(g)						
	3.1-14(i)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID:

000170

If continuation sheet

Page 30 of 54

AND PLAN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 155270	A. BUIL	A. BUILDING 00		(X3) DATE SURVEY COMPLETED 03/25/2011	
NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG IN	NC		STREET .	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
record review, the adequate supervis wanderguard, with to respond to door manner and/or have photograph in elogensure door mechasecured the wander of 3 residents revision with the potential residents on the dewanderguards (a residents which are to prevent unsuperunit). Resident #35, #5, Findings include: During initial tour 3/21/11 at 8 A.M. observed: The fact lane county road. unlocked entry do building, which confollowed by anoth which entered into building. The man extended to the right both with patient in the supervision of the supervision with patient in the supervision with the supervision with the supervision with the supervision with the supervision with the supervision with the supervision with sup	pement book and/or anism adequately erguarded resident for 1 ewed on the dementia guards in a sample of 12, to affect 14 total ementia unit with device which is worn by re at risk for elopement rvised exit from the #15, #42	F032	23	1. It is the policy of this facility ensure the resident environme remains as free of accident hazards as is possible; and ea resident receives adequate supervision and assistance devices to prevent accidents. Staff will respond to all door ar personal alarms immediately. Photographs will be placed in Elopement book within 24 hou of Wanderguard order. The Maintenance Supervisor adjust the door and added one closur to the affected door. Resident 35, #5, #15 and #42 now have photos in the elopement book. Upon admission or an elopement order photographs will be take and placed in the book within 2 hours.3. Staff will be inservice to respond to ALL alarms immediately. The elopement policy now states photographs be taken within 24 hours upon receipt of wanderguard order a placed in elopement book. An the door will be monitored daily the Maintenance Supervisor for one month and monthly after.4. All staff will monitor alarms by responding immediately to alarms. The Director of Nursing will monitor the elopement book weekly x 2 weeks, biweekly x 4 weeks and monthly thereafter. The Maintenance Director will monitor the door weekly for on month and then biweekly for on month and then biweekly for on month and monthly thereafter.	nt ch d irs ted ee s # 2. ent n 24 d will ind d / by r for	04/24/2011

Facility ID:

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET COMPLET					
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	03/25/20	
		133270	B. WIN			03/23/20	711
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CORF O	F HUNTINGBURG I	INC		1	N47523		
				<u>.</u>			(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	lock and alarm w	hen approached by a					
		anderguard. One of the					
		d edge to it. Upon entry					
		nit was an upside down					
		an exit door at each end.					
		is also alarmed for					
		d exits to the outside,					
		ard on the back side of					
	the building.						
	The clinical reco	rd of Resident #35 was					
	reviewed on 3 /2	1/11 at 12:50 P.M.					
	Diagnoses includ	led but were not limited					
	_	Dementia, Depression,					
	_	tive Pulmonary Disease,					
		Disorder, Diabetic Type					
		nistory of stroke. The					
	most recent MDS	S (minimum data set					
		d 2/27/11 indicated the					
	following for the	resident: short					
	tempered/easily a	annoyed several days;					
	verbal behaviora	al symptoms exhibited					
		curred 1 to 3 days;					
		locomotion on and off					
	unit required sup	ervision - oversight,					
		or cueing; height 64					
	I -	inches) weight 196					
	pounds.	, •					
	The resident was	admitted to the facility					
	on 2/18/11. An a	admission assessment					
	was dated 2/18/1	1. The assessment					
	included, but was	s not limited to, the					
	following: reside	ent is independently					

000170

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00		ESURVEY PLETED 2011	
	PROVIDER OR SUPPLIEF		•		DDRESS, CITY, STATE, ZIP CO ST MEDCALF N47523	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
mg	\	ely impaired and is exit		IAG			DAIL
	2/22/11 included the following: "memory impaire moderately impa Nurses notes ind On 2/18/11 at 13 "Resident arrive ambulatorySe unit - wander gu	icated the following: 30 (1:30 P.M.): d to facility veral attempts to leave ard on. Has been getting when redirected from					
	At 2:30 P.M. "B anxious with agg staffconstantly rooms and pullir frequent redirect staff attempts to Documentation in 15 minute check until 2/21/11 at 3.30 P.M. "R attempting to ex Showing s/s (sig aggression"	ecoming increased gression toward active, wandering into a tocked doors - ion with agitation when redirect" Indicated resident was on s starting at 2:30 P.M.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	r 1	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		p. wire	STREET A	DDRESS, CITY, STATE, ZIP COD ST MEDCALF N47523	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	\	ing room) few times.					
	At 10:00 P.M.: 'attempt to open 6	"cont (continue) to exit doors"					
	redirect. Trying to exit door et (as	:10 A.M.: "Very hard to to elope from unit. Goes nd) pulls on ittried to tries to elope from both					
	At 1 P.M.: "Tryi redirects poorly it	ng to exit unit againbut from exit."					
	placed in w/c (w)	Packed clothing et (and) heelchair). Attempting to ery resistive et becoming					
	get out of locked pull doors and se	g at nurse as she tries to unit. Cont (continue) to					
	the following: "	wated 2/21/11, indicated Wandering, potential for ety risk related to: Lost, mental stimuli"					
	On 2/21/11 at 6:4 multiple x's (time	40 P.M.: "exit seeking es)"					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	URVEY				
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	COMPLE 03/25/20	
		155270	B. WIN			03/23/20	711
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COPE O	F HUNTINGBURG I	INC		1	ST MEDCALF N47523		
				<u>.</u>	1147 020		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
mo	REGULATORTOR	ESC IDENTIFY THIS IN ORIMITION	-	1710	<u> </u>		DAIL
	On 2/22/11 at 10	:00 A M : " discripted					
	On 2/22/11 at 10:00 A.M.: "disoriented to time et place. Wandering more today et						
	_	redirectrequires 1:1					
	attention"	redirectrequires 1.1					
	attention						
	On 2/24/11 at Q I	P.M.: "Is constantly					
	trying to open un						
	l trying to open un	III u 001					
	On 2/26/11 at 00	20 (12:20 A.M.):					
		ie) to exit seek setting					
	`	s inappropriate comments					
		s and staff. Redirection is					
		anderguard on left					
	ankle"	anderguard on left					
	alikie						
	On 2/27/11 at 10	:00 A.M.: "Has been					
		oting to seek exit from					
		accessful et resident on					
		h redirection. Very					
	_	npting these behaviors et					
		t." This entry was					
	documented by F						
	a deamented by F	Q (1).					
	On 3/23/11 at 9 A	A M RN #1 was					
		e indicated the resident					
		the unit but when she					
	stated "successfu						
	resident's 1:1 was						
	1001401110 1.1 Wu						
	On 2/27/11 at 12	P.M.: "Resident					
		rs with time after time					
		with nursing staff who is					
	1	h her and doors to prevent					
	0000000	p. p. • . • •					

000170

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 03/25/2	ETED	
	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ST MEDCALF N47523	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	her leaving unit- figured our syst constant pressur displayed physic CNA (certified in nurses" At 5:45 P.M.: "Veloors enough to on the way down exited before the Resident was con- was cursing. Stat this resident all s out of resident ro nurses area" At 8:30 P.M.: ". to leave unit. Ca- but has been most On 3/1/11 at 9 A times to exit unit difficult to redire At 10:30 A.M.: Has a bag of clot attempting to leave Very difficult to re-	whas wanderguard but has em will release after re. Very agitated et cal aggression with nursing assistant) and Was able to pull on unit get them open. Staff was hallway, but resident y could reach her. In the properties of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155270	A. BUII		00	03/25/20	
		100270	B. WIN		A DDDEGG CITY GTATE ZID CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG I			1	N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	On 3/3/11 at 12:40 P.M.: "continual attempts to elope from unit - from front						
		r - very aggressive with					
	staff; yelling loud	_					
	attempting to red						
	unredirectable -	guarding the exits"					
	On 3/4/11 at 1 P.	M.: "Intensely trying to					
		eakfast and 10:30 A.M.					
	Went to both exit						
	elope"						
	1						
	At 9:30 P.M.: "V	Wandering into rms					
	(rooms) exit seek	sing attempting to					
	become phy (phy	vsically) agg					
	(aggressive)"	37 66					
	On 3/11/11 at 8 F	P.M.: "Resident has tried					
	most of evening	to elope - difficult to					
	redirect at x's (tir	nes)"					
		30 P.M.: "Res exhibiting					
	elopement behav	riors."					
	0 2/16/11 12:1	17 D.M. 14 D.M. "D					
		15 P.M. and 4 P.M., "Res.					
	exhibiting eloper	nent benaviors."					
	On 3/17/11 at 9:3	30 A.M., "Increased					
		morning. Pulling on unit					
	doors, attempting						
	, ,	_ 1					
	On 3/19/11 at 9 A	A.M.: "Resident					
	verbally aggressi	ve et trying to elope all					
	shift. Redirects p	poorly"					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	COMPLI 03/25/20	
		155270	B. WIN			03/23/20	711
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG I	INC		1	EST MEDCALF N47523		
				<u>l</u>	1147323		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
mo	REGULATORI OR	ESC IDENTIFY THOSE IN ORMATION		1710	<u> </u>		DAIL
	At 2 D M · "Dog	has been combative					
		reluctant to change					
	· ·	een exit seeking and will					
		unds solid and then walk					
	out"	unds sond and then wark					
	Out						
	Nurges notes deta	ed 3/20/11 at 12:30 P.M.					
		owing: "Tried to leave					
	unit. More diffic	2					
	unit. More diffic	cuit to redirect.					
	Nurses notes det	ed 3/20/11 at 1:45 P.M.					
		owing: "Got out of unit,					
		rsing. Went on a walk					
		e of unit. Tried to go					
		ive." This entry was					
	documented by I	LPIN #1.					
	On 2/22/11 of 11	:30 A.M., LPN #1 was					
		rding the above entry.					
		e resident "didn't really					
		She indicated "I was the					
	~						
	1	unit at the time" and she					
	·	,					
		e door was opened. She					
		dent got the door opened					
	'	ant pressure on it. She					
		nmoned help from the					
		aff walked the resident					
		indicated the resident					
		being returned inside					
	the building.						
	NI t 1 t	. 1 2 /20 /11 2 D 3 #					
	Nurses notes date	ed 3/20/11 at 3 P.M.					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00		COMPL	
		155270	B. WI				03/25/2	011
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	•		DDRESS, CITY, STA	TE, ZIP CODE		
				1	ST MEDCALF			
CORE O	F HUNTINGBURG I			」 DALE, I	N47523			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFI	ICIENCY)		DATE
		lowing: "Haldolgiven						
	after another atte	empt to leave unit"						
		30 P.M., Facility Staff #1						
		escort wanderguarded						
		east unit for a smoke						
		door adjacent to the						
		ilding). As residents						
	1 ^ ^	or, the alarm sounded.						
		observed to be escorted						
	back a distance fi	from the door and the						
	alarm ceased sou	inding. Staff #1 was						
	observed to enter	r a code to a key pad						
	located on the wa	all beside the exit door.						
	Staff #1 then ope	ened the door and						
	escorted the resid	dents out of the unit. As						
	the residents wer	re exiting the unit, the						
		ound again. The door						
		arm stopped sounding.						
		ann stopped sounding.						
	At 1·35 P.M. Re	esident # 35 was observed						
	1	it door of the unit. The						
		d no visual characteristics						
		r as an cognitively						
		t. She was observed to						
	1 ^	the door, crying. CNA #3						
	~	resident and escorted her						
	off the unit.	estaent and escorted net						
	on the unit.							
	On 2/22/11 -4 11	·20 A M DN #2						
		:30 A.M., RN #2 was						
		a photograph of Resident						
	#35.							
	0.000111	DM d Ef						
	On 3/22/11 at 12	P.M., the Elopement						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	RH6Y11	Facility l	ID: 000170	If continuation sh	eet Pa	ge 39 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI		
AND PLAN	OF CORRECTION	155270	A. BUI		00	03/25/20	
		100270	B. WIN		A DDDEGG CITY GTATE ZID CODE	00/20/20	711
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG I	NC		1	N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	\	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ire unit was observed.					
		total of 15 resident					
	_	Current photographs					
	_	4 residents, of which					
	included residen	ts #35, #42, #15 and #5.					
	•	ne DON was interviewed.					
		facility camera broke					
		left on vacation (on					
	· ·	aff member was going to					
	1	camera to use. She					
		nts #5 and #15 refused to					
	_	taken. Resident #42 had					
		the unit on 3/2/11 and					
		been admitted to the					
		The DON indicated there					
		ent book in the facility					
	which was house	d on the east unit.					
		30 P.M., a current,					
		the policy and procedure					
		Policy and Procedure"					
		the SSD (social service					
		olicy included, but was					
		e following: "maintain a					
	_	list of names and					
		esidents identified to be					
	at risk for elopen	nent"					
	On 3/22/11 at 2 I	P.M., the Maintenance					
	man was observe	ed working on the					
		door to the East unit.					
	He indicated it is	very windy outside					
	today and when t	hat happens, it creates a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	COMPL 03/25/2	
		133270	B. WIN			03/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF		
CORF O	F HUNTINGBURG I	NC		1	IN47523		
		TATEMENT OF DEFICIENCIES		ID	I		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	vacuum in the bu	ilding when both smoke					
		nd sometimes the east					
		close all the way. He					
	indicated he was	adjusting the tension on					
	the east unit door	rs to address the above					
	situation.						
	On 3/22/11 at 1:5	50 P.M., Resident #35					
	was observed app	proaching the interior,					
	unit exit doors.	The doors had not been					
	fully closed and	light was able to be					
	observed between	n the doors (of which one					
	was lipped). The	e alarm sounded as					
	Resident #35 was	s walking towards the					
	ajar doors. The o	loor had a window					
	_	per portion. Resident					
	#35 opened the d	oor and stood in the					
	1 *	a facility visitor blocked					
		unit, the resident was					
	_	exiting the unit and was					
	1	ersation. The resident					
	was standing at t						
		staff were observed in the					
		kterior unit hallway. At					
		#4 approached the					
		ide the unit. At this time,					
		oached the unit from the					
		e indicated the reason the					
		sed/latched was due to					
		and the air flow/pressure					
	_	He indicated "a whole lot					
		rough here when the					
	_	n east hall for the					
	residents to go or	utside for smoke breaks."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270			A. BUII	LDING	NSTRUCTION 00	СО	ATE SURVEY MPLETED 25/2011
NAME OF PROVID			B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COI ST MEDCALF N47523		
(X4) ID PREFIX	SUMMARY ST	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION
He i	indicated the	wind creates a vacuum en't close all the way.		TAG	DEFICIENCY)		DATE
On a currinter follounit to an indi the wan super 8:30 P.M. On a inter doct adm resid indi place history this "Elo prev 3/22 limi elop leav mobile restal individual	arently working reviewed. She owing times, it are escorted in outside area icated resident unit for supernderguard in pervised smoke 0 A.M., 10:30 ft., 6:30 P.M., 3/22/11 at 2:4 reviewed. She umentation whission elopendent in the clicated the reside on her on according of elopement plan wention and modern and modern time, the DO open time, the DO open to the follower of the follo	0 P.M., RN #1, who is g on the east unit, was indicated at the resident's from the east by staff off the unit and to smoke. She the wised smoking, do have a lace. She indicated the etimes are as follows: A.M., 1:30 P.M., 3:30 and 8:30 P.M.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	03/25/2	
		155270	B. WIN			03/23/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CORF O	F HUNTINGBURG I	NC		1	N47523		
				<u> </u>			(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	On 3/23/11 at 9 #	A.M., nurses notes for					
		iewed. They included					
		ted to the following:					
		fter a 1 P.M. note): At 6					
	1 `	to monitor for changes";					
		ased behaviors, mult					
	(multiple) attemp	· ·					
	1	staff, when redirection					
		cumentation was lacking					
		umstances of the resident					
		r open on 3/22/11 at 1:50					
	P.M.	1 op on on 5/22/11 w 1.0 o					
	1						
	On 3/23/11 at 10	:45 A.M., LPN #1					
	provided a currer	nt copy of the CNA					
	(certified nursing	g assistant) assignment					
	sheet. This form	indicated of the current					
	17 residents on th	ne unit, 14 had					
	wanderguards on	. Of the 4 residents					
	without current p	hotographs, all 4					
	_	nderguards in place, 2 of					
		fused to have photos					
	taken. (Resident	#35, #5, #15, #42).					
	On 3/23//11 at 11	A.M., the SSD (Social					
	Service Director)	and DON (Director of					
	Nursing) were in	terviewed. They					
	indicated the abo	ve 2 P.M. entry did not					
	indicate the resid	ent was off of the unit.					
	They indicated th	ney were not aware of the					
	resident having g	otten off the unit at any					
		cated the reason the					
	resident was adm	nitted here was because at					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155270	A. BUI	LDING	00	03/25/2	
		133270	B. WIN		PRESIDENCE CONTROL CON	03/23/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CORE O	F HUNTINGBURG	INC		DALE, I			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE.	DATE
	the facility she w	as at prior to this					
	admission, she el	loped from the building.					
		:15 A.M., RN #2 was					
		e indicated the reason the					
		unit (which are alarmed					
		d by a resident with a					
	1 '	e alarmed is"so staff					
	knows she is the	re."					
	On 3/24/11 at 1:3	30 P.M., the SSD was					
		e indicated the facility					
	"really doesn't ha	•					
	1 *	monitoring" and					
	1 -	e the care plan "Behavior					
		replan." She indicated a					
		on 15 minutes checks if					
		ical or verbal behavior					
	1	is kept on 15 minute					
		urs. She indicated the					
		1:1 monitoring if the					
	_	le to be redirected or acts					
	out at someone e	lse. She indicated this					
	resident has "bee	n on 1:1s a lot." She					
	indicated the faci	ility didn't really have a					
	1:1 tracking form	they just document in					
	the chart "1:1" ar	nd continue this until the					
	resident is calm.	If the resident is not					
	calmed down in	2 hours, the physician is					
		ntions included but were					
		following: "Allow					
	_	ss feelings: Allow					
		lly guide you through the					
	ADL (activities of	of daily living) process;					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
AND TEAN	or conduction	155270		LDING		03/25/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ST MEDCALF		
	F HUNTINGBURG I			DALE, I			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
ing	\	ving inappropriate	1	ing	·		DATE
		ow quiet time; provide					
		and allow quiet time;					
		g coping strategies;					
	,	nificant) behavior					
	1	safety of residentcontact					
		og behavior on 72 hour					
		d nurses notes,use one					
		until beh (behavior)					
	resolved: 1:1, 15	min checks, med change					
	per MD (medical	l doctor)"					
	On 3/24/11 at 2 I	P.M., the DON was					
	interviewed. She	e indicated staff get so					
	used to hearing the	he exit door alarms on					
	the unit.						
	On 3/25/11 at 6:3	30 A.M., CNA #3 (who					
		the east unit) was					
	interviewed. She	, , , , , , , , , , , , , , , , , , ,					
	wanderguarded r	esidents get close to the					
		alarms. She estimated					
	the distance from	a wanderguarded					
	resident to the un	nit exit door to trigger the					
	alarm, as being a	bout 17 feet. She					
	indicated for war	nderguarded residents to					
	1	ough the alarmed exit					
		ng would happen: If					
	1 -	gh away from the door,					
	the door can be o	•					
		esident can exit but the					
		; if the code is entered on					
		alarm will not sound for					
	10 seconds and the	he resident can exit. She					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
7 II VD T LAIN	or condition	155270	- 1	LDING		03/25/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ST MEDCALF		
CORE O	F HUNTINGBURG	INC		DALE, I	N47523		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	\	utton is pushed on the		-			
		outside the unit, the					
	1	und but "it (the button) is					
	really touchy, if	you move the least little					
	bit it will alarm."	She indicated when					
	residents go off t	he unit for smoke breaks,					
	1	sounds as it takes the					
		ents smoking long enough					
	1 -	e door, that the alarm					
	sounds.						
	On 2/25/11 at 7	A M. dha A durinistantan					
		A.M., the Administrator					
		She indicated only staff					
		enter in on the keypad.					
		atton on the outside of the you let off the button, the					
	_ ·	if a wanderguarded					
		The Administrator					
		y way to silence the					
		inderguarded resident is					
		feet on the inside) is to					
		on the outside or move the					
	resident out of ra						
		-					
	On 3/25/11 at 10	:15 A.M., the					
	maintenance mar	n was interviewed. He					
	indicated "it need	ded to be real windy and					
	have both sets of	doors open to the					
	outside" to be a p	problem with the					
	wanderguarded d	loors not closing					
	properly.						
	2.1.45(.)(2)						
	3.1-45(a)(2)						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/25/2011		
	PROVIDER OR SUPPLIER F HUNTINGBURG			510 WE	ADDRESS, CITY, STATE, ZIP CODE EST MEDCALF IN47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	TE	(X5) COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAU	DE RELACT)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

000170

Facility ID:

If continuation sheet

Page 47 of 54

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155270 03/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 510 WEST MEDCALF CORE OF HUNTINGBURG INC DALE, IN47523 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE It is the policy of this facility to F0431 Based on observation, record review and F0431 04/24/2011 store all drugs and biologicals in interview, the facility failed to ensure safe SS=E locked compartments under refrigeration temperature ranges for drug/ proper temperature control.1] All biological storage on 2 of 2 units improperly stored medications were re-ordered March 5, 2011 involving 13 of 13 residents using that and the improperly stored storage, with the potential to effect 45 medications were destroyed per residents. Resident #46 Resident #22 policy.2] A Medication refrigerator Resident #36 Resident #43 Resident #3 was purchased and placed on Resident #29 Resident #25 Resident #42 East Wing medication room. West Wing medication Resident #35 Resident #45 Resident #6 refrigerator was also replaced Resident #15 Resident #4 with a newer model.31 The facility will continue to monitor Findings include: refrigerator temperatures nightly with the "Refrigerator and Crash Cart" form.4] All medication On the West unit on 3/25/11 at 10:15 refrigerators were numbered for A.M. the medication room refrigerator reference purposes.5] New thermometers were placed in the temperature was 20 F(Fahrenheit two medication refrigerators.6] degrees). The drug and biological All Licensed Staff will be contents were checked against inserviced, as of April 24, 2011, manufacturer applied labels and/ or concerning the importance of pharmacy applied storage direction labels. maintaining medication refrigerator temperature control The refrigerator contents included: a bag and reporting any discrepencies of intravenous sodium chloride solution immediately.7] A medication for Resident #46 labeled DO NOT refrigerator audit will be done FREEZE which was frozen solid, one daily x 2 weeks, weekly x 2 weeks, biweekly x 4 weeks, then dose pack of Resperdol 37.5 mg labeled monthly thereafter, per present to store in temperature range of 36-46 F policy. for Resident #22, nine unopened 1 cc(cubic centimeter) vials of Lorazepam 2 mg per cc and one unopened 30 cc bottle of Lorazepam all labeled DO NOT FREEZE for Resident #36, five unopened 1 cc vials of Lorazepam 2 mg per cc for Resident # 43, four unopened 1 cc vials of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID:

000170

If continuation sheet

Page 48 of 54

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIEF		510 WE	ADDRESS, CITY, STATE, ZIP C EST MEDCALF N47523	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAU	Lorazepam 2 mg labeled DO NOT 1 cc vial of Lora Resident #29 and Lorazepam 2 mg In addition to rethe refrigerator a stock supply in a Kit (EDK) labeled contained one ur Ativan 2 mg/cc, vial of Insulin N unopened dose of There was also a Pneumovax vaccunopened via, la F and DO NOT 1 The monitoring medication refrigues and provide temperatures had night shift. In the recorded temperature of 25 days. In the freezing temperature to 32 F. for as loon the East unit the refrigerator to the state of th	sper cc for Resident #3 FREEZE, one unopened zepam 2 mg per cc for 12 unopened 1 cc vials of 3 per cc for Resident # 25. sident's individual drugs lso contained a general locked Emergency Drug ed DO NOT FREEZE. It sopened 5 cc vial of one unopened multi dose ovolin R and one of Novolog Insulin. facility supply of sine, one multidose beled to store 36 F to 46	IAG	DEFENSE		DAIE
		itoring log indicated				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155270		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI	COMPLETED 03/25/2011			
NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF DALE, IN47523					
	SUMMARY S (EACH DEFICIEN REGULATORY OR freezing temperal recorded days with freezing temperal The contents of the follows: one Resperdol and vials of Loral FREEZE for unopened 1 mg/cc for Resident #45 FREEZE, for Lorazepam 2 FREEZE for same for Resident #4 cc vials of L NOT FREEZ refrigerator. On interview with on 3/25/11 at 11: the West unit refrigered and she		STREET A	EST MEDCALF	RECTION OULD BE	(X5) COMPLETION DATE		
	month. 3.1-25(m)							

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PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/25/2011		
NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF DALE, IN47523				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RH6Y11

Facility ID: 000170

If continuation sheet

Page 51 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
	155270		B. WING			03/25/2011	
NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF DALE, IN47523				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		E	(X5) COMPLETION DATE	
F0441 SS=E	Based on record aphysicals / mantotest) the facility fremployees with the tuberculosis exposymptoms of othe diseases in a same records with a poresidents. RN #2 Cook #1 Findings include: On 3/23/11 at 9:0 records were revisive / mantouxs were their start of employee in the records with a poresidents. RN #2 cook #1. RN #2's employee initial second step was signed and distart date of 1/7/11 CNA #1's employed initial second step was signed and distart date of 2/16.	review and interview of buxs (tuberculosis skin failed to screen the two step method for osure detection or er potential contagious ple of 4 of 4 employee stential to affect 45 c, CNA #1, CNA #2 and where the series of the step of the	F044		1. It is the policy of this facility screen all employees with the t step method for tuberculosis exposure detection or symptom of other potential contagious diseases. The facility will give PPD prior to hire and the secon step will follow one to three weeks after initial PPD.2. Affected Employees include CN #1 and 2, Cook #1 and RN #1. All employees have had chest XRays to rule out active TB. 3 new PPD policy has been implemented to ensure 2nd step PPDS are given to all new employees. A file has been placed at the West Wing Nurse station to ensure the employee may be given the 2nd step in the allotted time frame by a qualified nurse. Once the 2nd step is complete the completed ppd for will be forwarded to the Administrator. 4. The Administrator will ensure compliance by monitoring PPD forms weekly for six weeks and then monthly.	wo ns a and NA A p es ne ed	DATE 04/24/2011
	initial second step	tial second step mantoux. The physical					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155270		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING			PLETED			
NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF DALE, IN47523					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	was signed and of start date of 1/28	lated for 3/23/11 after the /11.						
	Cook #1's employee record was lacking an initial second step mantoux. The physical was lacking from the employee file.							
	An interview with the Administrator, 3/23/11 at 12:45 P.M. indicated, "Cook #1 did not show up when the Medical Director was in the facility to do the physicals."							
	An interview with the Inservice Director, 3/23/11 at 10:50 A.M., indicated the second step mantouxs were not completed in the mantoux record.							
	3.1-18(a) 3.1-18(b)(6) 3.1-18(h)							

PRINTED: 04/25/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/25/2011		
NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 510 WEST MEDCALF DALE, IN47523				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	(EACH DEFICIEN			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DEFICIENCY)		DATE

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